



Phone: 1-877-537-0722

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Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Brand-name Antipsychotic
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

DOB: _____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI: _____

City: _____ State: _____ Medicaid ID: _____

Phone: _____ Fax: _____

Injectable antipsychotic medications are intended for administration in a clinic or hospital setting, rather than in the home. As the treating physician, I confirm that this drug is not stocked in my office for Medicaid Beneficiaries or non-Medicaid patients. Further, I confirm that this drug will be delivered to my office by clinic or pharmacy personnel only for administration by a clinical staff member.

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature

Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider ID#: _____

City: _____ State: _____ Phone: _____

Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ NDC: _____

Diagnosis: _____

Medical Justification for injectable antipsychotic:

Is this patient receiving oral antipsychotic therapy? ____ Yes ____ No

If yes, indicate the intended duration of oral antipsychotic therapy: _____

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